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| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610a)<br>300.1210b)<br>300.1210d)1)3)<br>300.1620a)<br>300.1620b)<br>300.1630)2<br>300.3220f)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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seven-day-a-week basis:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record
Section 300.1620 Compliance with Licensed Prescriber's Orders
a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.
b) Telephone orders may be taken by a registered nurse, licensed practical nurse or licensed pharmacist. All such orders shall be immediately written on the resident's clinical record or a telephone order form and signed by the nurse or pharmacist taking the order. These orders shall be countersigned by the licensed prescriber within 10 calendar days.
Section 300.1630 Administration of Medication
2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose.
Section 300.3220 Medical Care
f) All medical treatment and procedures shall be administered as ordered by a physician. All new

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physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
These requirements are not met as evidenced by:

Based on interview and record review, the facility neglected to correctly administer and document the anti-coagulant medication, Warfarin as ordered by the physician, for one of two residents (R2) reviewed for the neglect in the sample of 4. This resulted in R2 receiving too much Warfarin, which caused an elevated Prothrombin Time (PT or Protime) and INR (international normalized ratio), spontaneous internal bleeding of the right lower extremity, anemia and an elevated heart rate. As a result, R2 was hospitalized and received an injection of Vitamin K and a transfusion of packed red blood cells.

Findings include:

1. The facility's policy and procedure, dated 7/03/2013 and entitled, 'Medication Administration' documents, in part, "The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recoding the time and dose given. When preparing medication for administration, check the label of the drug container at minimum three times for safety and accuracy. Report errors in medication administration immediately per

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policy. Report suspected adverse reaction immediately per policy."

2. The facility's policy and procedure, dated 7/01/2012 and entitled, 'Notification for Change in Resident or Status' documents, in part, "The nurse supervisor/charge nurse will notify the resident's attending physician or on call physician when there has been: A discovery of injuries of an unknown source; a significant change in the resident's physical/emotional/mental condition; a need to transfer the resident to a hospital/treatment center; abnormal lab findings. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status."

3. The Geriatric Dosage Handbook, 12th Edition, page 1646, documents, in part, "Warfarin (Coumadin) High alert medication: The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error. Overdose/Toxicology-Symptoms include internal or external hemorrhage and hematuria. When an overdose occurs, the drug should be immediately discontinued and vitamin K (phytonadione) may be administered, up to 25 mg IV (intravenously). When hemorrhage occurs, fresh frozen plasma transfusions can help control bleeding by replacing clotting factors."

4. The Physician's Order Sheet (POS) for 6/2016 documents diagnoses for R2, in part, as Hypoxia, Pulmonary Edema, Hypertension, Atrial Fibrillation and Coronary Artery Disease. The Physician's Order (PO) on admission, dated 6/16/2016, documents R2 was admitted with an order for the anti-coagulant medication of

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Warfarin, 6 milligrams (mg) by mouth daily on Sunday and Wednesday, and Warfarin 5 mg daily on Monday, Tuesday, Thursday, Friday and Saturday. R2 also had a PO, dated 6/16/2016, for Aspirin Chewable 81 mg daily, which also has blood thinning properties.

A Laboratory Report, dated 6/17/2016, documents R2 had a PT of 18.9 seconds (normal=9.2-12.6 seconds) and an INR of 1.8 (normal=0.8-1.2). There was no PO for a change in Warfarin dosage at that time from Z5 or Z9, Physician's.

The Nurse's Note from E10, Licensed Practical Nurse (LPN), dated 6/26/2016 at 7:00 PM, documents, "CNA (Certified Nurses Aide) went to check on resident (R2) and found a large amount of bluish discoloration of right leg, measurements 20 cm (centimeter) X 5 cm. Patient states she's in pain. PRN (as needed) pain medication noted. (Z6), Nurse Practitioner paged and awaiting call back. DON (E2, Director of Nursing) called, Administrator (E1) word/message left to call facility as soon as possible."

The Nurse's Note from E10, dated 6/26/2016 at 8:00 PM, documents, "N.O. (new order) apply ice, get PT/INR in the AM." There is no written PO for this in R2's clinical record. The Nurse's Note from E8, LPN, dated 6/26/2016 at 11:30 PM, documents, "Lab here to draw PT/INR. Specimen taken from left forearm. Awaiting results."

The Nurse's Note from E8, dated 6/27/2016 at 2:00 AM, documents, in part, "Lab called facility to notify this nurse of critical labs. PT results over 100 (normal=12.0-18.5 seconds on this report)." The Nurse's Note from E8 documents a call was placed at 2:05 AM of 6/27/16 to Z5's,

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Physician/Medical Director, office with an urgent page requested. E8 then documents on 6/27 at 3:10 AM, Z5's office was called again related to the critical laboratory reports for R2 with no response. E8's Nurse's Note, dated 6/27/2016 at 3:26 AM, documents E2 was called and a message was left to return the call. E8 documents in the Nurses Note that at 3:36 AM, E2 called back with an order to send R2 to the local hospital. E8's Nurses Note documents Z4, Nurse Practitioner, returned the call at 3:50 AM on 6/27 and was informed of the critical PT, and agreed to send R2 to the hospital. At this time, 8 hours and 50 minutes had passed since E10 left the first urgent message at Z5's exchange about R2's new large bruise to the right leg, and 1 hour and 45 minutes since E8 called to report the critical PT results for R2. The Nurse's Note from E8 documents R2 left the facility by ambulance at 4:30 AM on 6/27/2016.

The Resident Transfer Form completed by E8 on 6/27/2016 at 3:00 AM, documents R2's vital signs as BP (blood pressure) is 102/84, heart rate 86, respirations of 20, temperature of 97.3 Fahrenheit, and pulse oximeter of 97 percent.

R2's Emergency Room (ER) Visit Report, dated 6/27/2016, documents R2 was seen by Z10, Physician, at 6:02 AM. The ER Report documents that R2's RBC (red blood cells) were low at 1.92 (normal is 3.9 to 5.3 million cells per microliter), a low hemoglobin of 6.5 (normal is 12.0 to 15.5 grams/deciliter), and hematocrit is 20.7 percent (normal is 34.9-44.5 percent), high platelet count of 471 (normal is 150 to 450), elevated PT of 50.9, and INR of 5.72 and an elevated PTT (partial thromboplastin time) of 62 seconds, (normal is 25=30 seconds). The ER Report documents, in part, "Lab results comment:

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Remarkable anemia and dehydration. new bruising noted on extremities, redness and tenderness of left lower leg. Clinical Impression: Abnormal laboratory test result, anticoagulated on Coumadin (Warfarin), dehydration, cellulitis of left leg, elevated INR."

The Hospitalist Discharge Summary, dated 7/01/2016, documents R2 was admitted to the local hospital on 6/27/2016 and, "Was found to have an elevated INR, a rather large hematoma in the right lower extremity, cellulitis of the lower extremities and a urinary tract infection with Pseudomonas (a bacteria), anemia secondary to chronic disease and secondary to acute blood loss in the hematoma. The patient was transfused a total of 2 units of packed red blood cells."

The facility's Medication Administration Record for R2 in 6/2016 documents R2 received 6 mg of Warfarin on Friday and Saturday, 6/17/2016 and 6/18/2016 at 4:00 PM, none on 6/19, 11 mg of Warfarin at 4:00 PM on 6/20, 6/21, 6/22, 6/23, 6/24 and 6/25/2016. Eight doses of Warfarin, 6 mg were given and 6 doses of Warfarin, 5 mg were administered to R2, totaling 14 doses. The nurses that documented this medication was given on those dates are E5, E6, and E10, LPN's. According to Z5's (Physician) orders, R2 was to only receive a 6 mg dose of Warfarin on Sunday 6/19 and Wednesday 6/22/2016.

On 7/08/2016 at 1:40 PM, Z7, General Manager for the facility's Pharmacy, reported 4 pills of 6 mg of Warfarin and 11 pills of 5 mg were delivered to the facility on 6/17/2016, with specific orders for what dose on what day were to be given to R2. Z7 reported these should have lasted 2 weeks, not 9 days. Z7 reported the

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facility failed to send any medications or empty cards back to determine what was given by the facility nurses. Z7 reported there is standard procedure for returning unused medication and a form to complete for the return. Z7 reported E2 told her the medication was sent back in a return tote, but E2 was unable to identify which nurse gave them to the pharmacy driver. Z7 identified R2's prescribing physician as (Z5).

The pharmacy's Shipment Details Invoice, dated 6/17/2016, documents the medication was received and signed for by E12, LPN, on 6/17 at 12:52 PM. The Invoice documents 4 tablets of 6 mg of Warfarin and 11, 5 mg tablets of Warfarin were signed for at that time. The prescribing physician is documents as (Z5).

On 7/08/2016 at 10:39 AM, Z5 reported, "I was not aware of this patient (R2)." Z5 reported he had never examined R2 since admission to the facility on 6/16/2016. Z5 reported too much Warfarin could cause bleeding or possibly death. Z5 reported he was unaware R2 received too much Warfarin or that the PT was over 100, critically high. Z5 reported he was unaware R2 was hospitalized or which one of his Nurse Practitioners (NP)sent her. Z5 stated, "There was a breakdown of communication for sure." The staff thought (R2) was a patient of (Z9's, Physician). Z5 reported that maybe his NP ordered the PT and INR.

On 7/07/2016 at 12:15 PM, E10 reported that on 6/26/2016, E7, CNA, reported to him a huge bruise to R2's right leg. E10 stated, "I know it had something to do with PT and INR. I called the DON (E2) and she told me not to send (R2) out, to talk to (E1, Administrator) first. I called and texted (E1). I called the exchange for (Z5). (E4,

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NP) called back with an order to do PT/INR in the AM. When third shift nurse (E8) came in, she said we can't wait until tomorrow morning. (E2) just threw it off on (E1). I texted (E1) about a bruise of unknown origin. I filled out a QA (quality assurance) paper about what I saw. The bruise looked really fresh. The lab came after I left. I asked (E2) if I should call (Z1, R2's Power of Attorney) and she told me to call (E1) first. (Z6) was on call, but (Z4) returned the call. Usually when you call the (Z5) exchange, they call back within 20 to 40 minutes. They are trying to cover themselves now. I did everything I was supposed to do. My last day to work was 7/06/2016. I got fired. I'm taking the fall for this. They didn't want you to talk to me."

On 7/07/2016 at 3:45 PM, E7 reported she found the bruise on R2's right leg and reported it to E10. E7 stated, "I want to say it was gray-blue in color. The right leg wasn't swollen. It was hot to the touch. (R2) complained of pain and said her legs hurt. (E10) put cream on her leg and gave her a pain pill. (E10) called the DON (E2) and I overheard the conversation. (E10) began to email and text department heads. (E2) told (E10) not to send (R2) out (to the hospital). He begged (E2) to send (R2) out. He completed an incident report and documented. I did not document anything. (E8) came in and (E10) gave report to her and told her to try to get ahold of (Z5), who didn't call back. (E10) scheduled a STAT (immediately) PT and INR before he left. E10 felt like it was because of Coumadin (Wafarin)."

On 7/07/2016 at 1:00 PM, E2 stated, "(E10) did not call me. Only (E8) called me and said the bruises are getting worse. I didn't speak to (E10) at all. I thought the bruises were getting worse due to the high PT and INR. There is no

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investigation started because it was not a bruise of unknown origin." When asked if E10 started an investigation about R2's bruise, E2 stated, "No, there is no investigation."

On 7/07/2016 at 3:00 PM, E2 was asked about the Warfarin administration for R2. E2 replied, "(Z2, Pharmacist) is counting pills returned to see if they gave both doses of 5 mg and 6 mg or if they (nurses) just signed it as given. I'm hoping they were careless in signing them as given. (E10) and (E5, LPN) are questioning about this. I don't understand why."

On 7/07/2016 at 1:38 PM, E5 stated, "(E10) came and got me the day (R2) was sent out. He showed me the bruises, and I told him to call (E2) and went to work to the other end. I told him to let me know what (E2) said so I can help him send (R2) out. I came back and asked (E10) if (R2) was being sent to the hospital. He replied (E2) said not to send her out. Then the night nurse came in, (E8) and she saved the day. (E8) called the doctor and got a PT/INR STAT and then sent her to the hospital when the results came in. (R2) was alert when she left the facility. She could talk on the phone." E5 reported she signed the MAR for R2 at 4:00 PM on 6/21, 6/22 and 6/23/2016 for the administration of Warfarin 5 mg and 6 mg. E5 reported she had been disciplined by E2 for not signing the MAR, so she signs it to fill in the blanks.

On 7/07/2016 at 1:20 PM, Z2 reported if a resident receives too much Warfarin their INR will be high. Z2 stated, "I just look at the INR. They would have to hold it. Warfarin can cause bleeding. The higher the INR, the more bleeding. If INR is over 4, probably hold Warfarin." Z2 reported if R2 received too much Warfarin, this is

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| S9999 | Continued From page 10<br>a significant medication error.<br><br>R2's Care Plan, dated 6/16/2016, documents, in part, "Anticoagulant/ At risk for increased bleeding. (R2) will not have severe bruising. Notify MD (medical doctor) as needed related to excessive bleeding. Observe for tarry stool. Labs per MD orders."<br><br>300.610a)<br>300.1210b)<br>300.1210d)1)3)<br>300.1620a)<br>300.1620b)<br>300.1630)2<br>300.3220f)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with | S9999 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record
Section 300.1620 Compliance with Licensed Prescriber's Orders
a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.
b) Telephone orders may be taken by a registered nurse, licensed practical nurse or licensed pharmacist. All such orders shall be immediately written on the resident's clinical record or a telephone order form and signed by the nurse or pharmacist taking the order. These orders shall be countersigned by the licensed prescriber

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| S9999 | Continued From page 12<br>within 10 calendar days.<br>Section 300.1630 Administration of Medication<br>2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose.<br>Section 300.3220 Medical Care<br>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.<br>Section 300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These Requirements are not met as evidenced by:<br><br>Based on interview and record review, the facility failed to administer medications as ordered by the physician, for one of two residents (R2) reviewed for medication administration in the sample of 4. This resulted in a significant medication error with R2 receiving too much Warfarin, which caused an elevated Prothrombin Time (PT or Protime) and INR (international normalized ratio), spontaneous internal bleeding of the right lower extremity, anemia and an elevated heart rate. As a result, R2 was hospitalized and received an injection of Vitamin K and a transfusion of packed red blood cells.<br><br>Findings include:<br><br>1. The Physician's Order Sheet (POS) for 6/2016 documents diagnoses for R2, in part, as Hypoxia, Pulmonary Edema, Hypertension, Atrial | S9999 | | |

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Fibrillation and Coronary Artery Disease. The Physician's Order (PO) on admission, dated 6/16/2016, documents R2 was admitted with an order for the anti-coagulant medication of Warfarin 6 milligrams (mg) by mouth daily on Sunday and Wednesday and Warfarin 5 mg daily on Monday, Tuesday, Thursday, Friday and Saturday.

A Laboratory Report, dated 6/17/2016 documents R2 had a PT of 18.9 seconds (normal=9.2-12.6 seconds) and an INR of 1.8 (normal=0.8-1.2). There was no PO for a change in Warfarin dosage at that time from Z5 or Z9, Physicians.

The Nurse's Note from E10, Licensed Practical Nurse (LPN) dated 6/26/2016 at 7:00 PM, documents, "CNA (Certified Nurse'sAide) went to check on resident (R2) and found a large amount of bluish discoloration of right leg, measurements 20 cm (centimeter) X 5 cm. Patient states she's in pain. PRN (as needed) pain medication noted. (Z6), Nurse Practitioner paged and awaiting call back. DON (E2, Director of Nursing) called, Administrator (E1) word/message left to call facility as soon as possible."

The Nurse's Note from E10, dated 6/26/2016 at 8:00 PM, documents, "N.O. (new order) apply ice, get PT/INR in the AM." There is no written PO for this in R2's clinical record. The Nurses Note from E8, LPN, dated 6/26/2016 at 11:30 PM, documents, "Lab here to draw PT/INR. Specimen taken from left forearm. Awaiting results."

The Nurse's Note from E8, dated 6/27/2016 at 2:00 AM, documents, in part, "Lab called facility to notify this nurse of critical labs. PT results over 100 (normal=12.0-18.5 seconds on this report)." The Nurse's Note from E8 documents a call was

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placed at 2:05 AM of 6/27/16 to Z5's office with an urgent page requested. E8 then documents on 6/27 at 3:10 AM, Z5's office was called again related to the critical laboratory reports for R2 with no response. E8's Nurses Note, dated 6/27/2016 at 3:26 AM, documents E2 was called and a message was left to return the call. E8 documents in the Nurse's Note that at 3:36 AM, E2 called back with an order to send R2 to the local hospital. E8's Nurses Note documents Z4, Nurse Practitioner returned the call at 3:50 AM on 6/27 and was informed of the critical PT, and agreed to send R2 to the hospital. At this time, 8 hours and 50 minutes had passed since E10 left the first urgent message at Z5's exchange about R2's new large bruise to the right leg, and 1 hour and 45 minutes since E8 called to report the critical PT results for R2. The Nurse's Note from E8 documents R2 left the facility by ambulance at 4:30 AM on 6/27/2016.

The Resident Transfer Form completed by E8 on 6/27/2016 at 3:00 AM, documents R2's vital signs as BP (blood pressure ) is 102/84, heart rate 86, respirations of 20, temperature of 97.3 Fahrenheit, and pulse oximeter of 97 percent.

R2's Emergency Room (ER) Visit Report, dated 6/27/2016, documents R2 was seen by Z10, Physician at 6:02 AM. The ER Report documents that R2's RBC (red blood cells) were low at 1.92 (normal is 3.9 to 5.3 million cells per microliter), a low hemoglobin of 6.5 (normal is 12.0 to 15.5 grams/deciliter), and hematocrit is 20.7 percent (normal is 34.9-44.5 percent),high platelet count of 471 (normal is 150 to 450), elevated PT of 50.9, and INR of 5.72 and an elevated PTT (partial thromboplastin time) of 62 seconds, (normal is 25=30 seconds). The ER Report documents, in part, "Lab results comment:

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Remarkable anemia and dehydration. new bruising noted on extremities, redness and tenderness of left lower leg. Clinical Impression: Abnormal laboratory test result, anticoagulated on Coumadin (Warfarin), dehydration, cellulitis of left leg, elevated INR."

The Hospitalist Discharge Summary, dated 7/01/2016, documents R2 was admitted to the local hospital on 6/27/2016 and, "Was found to have an elevated INR, a rather large hematoma in the right lower extremity, cellulitis of the lower extremities and a urinary tract infection with Pseudomonas (a bacteria), anemia secondary to chronic disease and secondary to acute blood loss in the hematoma. The patient was transfused a total of 2 units of packed red blood cells."

The facility's Medication Administration Record for R2 for 6/2016 documents R2 received 6 mg of Warfarin on Friday and Saturday, 6/17/2016 and 6/18/2016 at 4:00 PM, none on 6/19, 11 mg of Warfarin at 4:00 PM on 6/20, 6/21, 6/22, 6/23, 6/24 and 6/25/2016. Eight doses of Warfarin, 6 mg were given and 6 doses of Warfarin, 5 mg were administered to R2, totaling 14 doses. The nurses that documented this medication was given on those dates are E5, E6, and E10, LPN's. According to Z5's (Physician) orders, R2 was to only receive a 6 mg dose of Warfarin on Sunday 6/19 and Wednesday 6/22/2016.

On 7/08/2016 at 1:40 PM, Z7, General Manager for the facility's Pharmacy, reported 4 pills of 6 mg of Warfarin and 11 pills of 5 mg were delivered to the facility on 6/17/2016, with specific orders for what dose on what day were to be given to R2. Z7 reported these should have lasted 2 weeks, not 9 days. Z7 reported the

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facility failed to send any medications or empty cards back to determine what was given by the facility nurses. Z7 reported there is standard procedure for returning unused medication and a form to complete for the return. Z7 reported E2 told her the medication was sent back in a return tote, but E2 was unable to identify which nurse gave them to the pharmacy driver. Z7 identified R2's prescribing physician as (Z5).

The pharmacy's Shipment Details Invoice, dated 6/17/2016, documents the medication was received and signed for by E12, LPN on 6/17 at 12:52 PM. The Invoice documents 4 tablets of 6 mg of Warfarin and 11, 5 mg tablets of Warfarin were signed for at that time. The prescribing physician is documented as (Z5).

On 7/08/2016 at 10:39 AM, Z5 reported, "I was not aware of this patient (R2)". Z5 reported he had never examined R2 since admission to the facility on 6/16/2016. Z5 reported too much Warfarin could cause bleeding or possibly death. Z5 reported he was unaware R2 received too much Warfarin or that the PT was over 100, critically high. Z5 reported he was unaware R2 was hospitalized or which one of his Nurse Practitioners (NP)sent her. Z5 stated, "There was a breakdown of communication for sure. The staff thought (R2) was a patient of (Z9's, Physician). Z5 reported that maybe his NP ordered the PT and INR.

On 7/07/2016 at 12:15 PM, E10 reported that on 6/26/2016, E7, CNA reported to him a huge bruise to R2's right leg. E10 stated, "I know it had something to do with PT and INR. I called the DON (E2) and she told me not to send (R2) out, to talk to (E1, Administrator) first. I called and texted (E1). I called the exchange for (Z5). (E4,

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NP) called back with an order to do PT/INR in the AM. When third shift nurse (E8) came in, she said we can't wait until tomorrow morning. (E2) just threw it off on (E1). I texted (E1) about a bruise of unknown origin. I filled out a QA (quality assurance) paper about what I saw. The bruise looked really fresh. The lab came after I left. I asked (E2) if I should call (Z1, R2's Power of Attorney) and she told me to call (E1) first. (Z6) was on call, but (Z4) returned the call. Usually when you call the (Z5) exchange, they call back within 20 to 40 minutes. They are trying to cover themselves now. I did everything I was supposed to do. My last day to work was 7/06/2016. I got fired. I'm taking the fall for this. They didn't want you to talk to me."

On 7/07/2016 at 3:45 PM, E7 reported she found the bruise on R2's right leg and reported it to E10. E7 stated, "I want to say it was gray-blue in color. The right leg wasn't swollen. It was hot to the touch. (R2) complained of pain and said her legs hurt. (E10) put cream on her leg and gave her a pain pill. (E10) called the DON (E2) and I overheard the conversation. (E10) began to email and text department heads. (E2) told (E10) not to send (R2) out (to the hospital). He begged (E2) to send (R2) out. He completed and incident report and documented. I did not document anything. (E8) came in and (E10) gave report to her and told her to try to get ahold of (Z5), who didn't call back. (E10) scheduled a STAT (immediately) PT and INR before he left. E10 felt like it was because of Coumadin (Wafarin)."

On 7/07/2016 at 1:00 PM, E2 stated, "(E10) did not call me. Only (E8) called me and said the bruises are getting worse. I didn't speak to (E10) at all. I thought the bruises were getting worse due to the high PT and INR. There is no

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investigation started because it was not a bruise of unknown origin." When asked if E10 started an investigation about R2's bruise, E2 stated. "No, there is no investigation."

On 7/07/2016 at 3:00 PM, E2 was asked about the Warfarin administration for R2. E2 replied, "(Z2, Pharmacist) is counting pills returned to see if they gave both doses of 5 mg and 6 mg or if they (nurses) just signed it as given. I'm hoping they were careless in signing them as given. (E10) and (E5, LPN) are questioning about this. I don't understand why."

On 7/07/2016 at 1:38 PM, E5 stated, "(E10) came and got me the day (R2) was sent out. He showed me the bruises, and I told him to call (E2) and went to work to the other end. I told him to let me know what (E2) said so I can help him send (R2) out. I came back and asked (E10) if (R2) was being sent to the hospital. He replied (E2) said not to send her out. Then the night nurse came in, (E8) and she saved the day. (E8) called the doctor and got a PT/INR STAT and then sent her to the hospital when the results came in. (R2) was alert when she left the facility. She could talk on the phone." E5 reported she signed the MAR for R2 at 4:00 PM on 6/21, 6/22 and 6/23/2016 for the administration of Warfarin 5 mg and 6 mg. E5 reported she had been disciplined by E2 for not signing the MAR, so she signs it to fill in the blanks.

On 7/07/2016 at 1:20 PM, Z2 reported if a resident receives too much Warfarin their INR will be high. Z2 stated, "I just look at the INR. They would have to hold it. Warfarin can cause bleeding. The higher the INR, the more bleeding. If INR is over 4, probably hold Warfarin." Z2 reported if R2 received too much Warfarin, this is

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a significant medication error.

R2's Care Plan, dated 6/16/2016, documents, in part, "Anticoagulant/ At risk for increased bleeding. (R2) will not have severe bruising. Notify MD (medical doctor) as needed related to excessive bleeding. Observe for tarry stool. Labs per MD orders."

The facility's policy and procedure, dated 7/03/2013 and entitled, "Medication Administration" documents, in part, "The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recoding the time and dose given. When preparing medication for administration, check the label of the drug container at minimum three times for safety and accuracy. Report errors in medication administration immediately per policy. Report suspected adverse reaction immediately per policy."

The facility's policy and procedure, dated 7/01/2012 and entitled, "Notification for Change in Resident or Status" documents, in part, "The nurse supervisor/charge nurse will notify the resident's attending physician or on call physician when there has been: A discovery of injuries of an unknown source; a significant change in the resident's physical/emotional/mental condition; a need to transfer the resident to a hospital/treatment center; abnormal lab findings. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status."

The Geriatric Dosage Handbook, 12th Edition,

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| S9999 | Continued From page 20<br>page 1646, documents, in part, "Warfarin (Coumadin) High alert medication: The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error. Overdose/Toxicology-Symptoms include internal or external hemorrhage and hematuria. When an overdose occurs, the drug should be immediately discontinued and vitamin K (phytonadione) may be administered, up to 25 mg IV (intravenously). When hemorrhage occurs, fresh frozen plasma transfusions can help control bleeding by replacing clotting factors."<br>( A) | S9999 | | |

**IMPOSED PLAN OF CORRECTION**

Facility Name: Swansea Rehab Health Care

Survey Date: July 12, 2016

Survey: Complaint 1643589/IL86582

Violation: A

Administrative Code:

**Section 300.610 Resident Care Policies**

300.610a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

**Section 300.1210 General Requirements for Nursing and Personal Care**

300.1210b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

300.1210d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

**Section 300.1620 Compliance with Licensed Prescriber's Orders**

300.1620a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by

Attachment B
Imposed Plan of Correction

the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

300.1620b) Telephone orders may be taken by a registered nurse, licensed practical nurse or licensed pharmacist. All such orders shall be immediately written on the resident's clinical record or a telephone order form and signed by the nurse or pharmacist taking the order. These orders shall be countersigned by the licensed prescriber within 10 calendar days.

## Section 300.1630 Administration of Medication

2) Each dose administered shall be properly recorded in the clinical record-by the person who administered the dose

## Section 300.3220 Medical Care

f) *All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders*

## Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident*

**This will be accomplished by:**

1. The Director of Nursing or designee will provide education to the facility staff on medical policies and procedures related to medication administration, transcription of physician orders, documentation and prompt reporting of errors identified.
2. Under the direction of the Director of Nursing or designee a plan will be implemented to monitor to assure compliance with policies and procedures related to medication administration, documentation and reporting errors.
3. The Administrator will provide oversight for continued compliance

Completion date: Ten days from receipt of the Notice for the Imposed Plan of Correction

August 26, 2016/ JP